Chapter Seven

Five Initiatives to Bend the Health Care Cost Curve

By Jack Meyer

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Introduction

Over the past several decades there has been a fundamental disconnect between government cost control policies and the underlying forces driving up health care spending. These forces include:

- The difficulty in determining which applications of advanced medical technology are clinically appropriate, and for whom. We have left cost out of the value equation: the preferred test is "safe-and-effective," with cost-effectiveness standards shunned as rationing.
- Poorly designed payment systems that encourage health care providers to proliferate services.
- An antiquated administrative system that leaves health care system participants drowning in paper.
- Prices for a whole range of health care products and services that greatly exceed those in other developed nations.
- The failure to adequately manage patients with chronic illness and disabilities, particularly those with a cluster of complex medical conditions. In fact, *two-thirds of Medicare spending is for people with five or more chronic conditions.*[1]
- The emphasis on designing and redesigning what some have called the sick care system, with too little emphasis on addressing the forces that drive people into poor health, such as smoking and obesity.

For the most part, our political leaders have chosen not to focus on these underlying cost drivers, but to engage in an annual charade of battling with health plans, physicians, hospitals, and other health care providers about the size of annual payment rate increases. Every year the federal government proposes a set of cuts to the growth rate of payments that is called for by some poorly designed formula. The provider groups push back. The pushing and shoving proceeds until some compromise is reached that resets the increases for another year.

This has two serious adverse effects. First, the continuous cuts in payment rates make government programs increasingly unattractive to physicians and other health care providers. Medicaid physician fees are only 72 percent of Medicare levels (66 percent for primary care services),[2] and this leads doctors to abandon the program in droves, a problem now beginning to spill over to Medicare, with frightening consequences for the future. Second, focusing mainly on allowable annual increases in prices papers over the enormous inefficiency in the cost base.

Simply stated, government is not a smart buyer of health care. This

is beginning to improve, and the Affordable Care Act (ACA) contains many seeds which, if properly planted, could bloom into a better approach to long-term cost management. But this is just a start.

Background

Federal government outlays are projected to rise by a total of $1.228 trillion over the decade from 2010 to 2020. On our current course, nearly 60 percent of this total increase, or $726 billion, is accounted for by the growth in spending for Medicare, the adult portions of Medicaid, and Social Security. Interest on the federal debt makes up most of the rest, accounting for another $468 billion, or 38 percent.[3]

There are many opportunities to improve health while generating Medicare savings. For example, one in seven Medicare patients will experience some adverse event such as a preventable illness or injury while in the hospital. One in three Medicare beneficiaries who leave the hospital today will be back in the hospital within a month. Medicare spent an estimated $4.4 billion in 2009 to care for patients who had been harmed in the hospital, and readmissions cost Medicare another $26 billion a year.[4]

If we do not find ways to redesign and slow the growth in outlays for Medicare and Medicaid (adult portion), along with Social Security, they will crowd out virtually all else in the federal budget. Another way to view this is that as important as they are, our commitments to the elderly, if not properly managed, will force us to renege on our commitments to our children. Discretionary federal programs that support children—ranging from Pell grants and Title I (Improving Academic Achievement for the Disadvantaged) to the Children's Health Insurance Program (CHIP) and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) program, among many others—would fall victim to the budget axe if Medicare, Medicaid, and Social Security are shielded from major change. Figure 7.1 shows the inexorable growth in the share of GDP accounted for by federal spending for Medicare, Medicaid, and Social Security under current law.

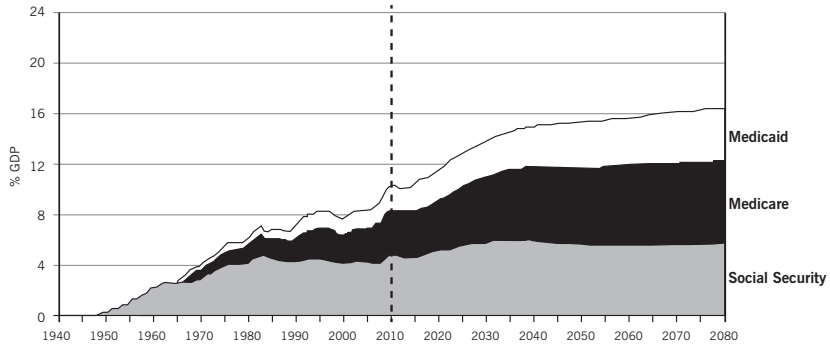
Moving to a Smarter Approach to Cost Control

A smarter health care cost control policy could be built around the following five initiatives:

Initiative One: Invest in Health Information Technology (HIT)

The United States has a mainly paper-based system of patient medical

Figure 7.1: Federal Medicaid, Medicare, and Social Security Spending as a Percent of GDP



Note: Authors used 2010 CBO data for Social Security, Medicare, and Medicaid through 2020, and grew Social Security and Medicare levels with Trustees data and Medicaid with CBO data.
Source: C.E. Steuerle and S. Rennane, The Urban Institute 2010. Based on earlier work with A. Carasso and G. Reynolds.

records. This system has been known to lead to medical errors, missed opportunities to improve patient care, unnecessary costs, and threats to patients' health (i.e. prescribing medication that may interact dangerously with another medication that a patient is taking). One study conducted by HealthGrades found that patients' risk of dying is more than 73 percent lower in the highest-rated hospitals versus the lowest-rated hospitals. If all Medicare patients from 2008 through 2010 had been treated at five-star hospitals, 240,040 lives could have potentially been saved. This would also translate into several billion dollars in savings.[5]

Under federal regulations released in July 2010, physicians and hospitals will have five years to demonstrate "meaningful use" of HIT. To achieve meaningful use, providers must demonstrate that they have mastered the use of electronic health records (EHRs) and are employing them in their practices. These electronic records would enable the providers to see the patient's full medical history in real time as they examine that patient, including care received in other settings; and to schedule appointments, send patient reminders, receive lab and other test results, and share notes with other physicians, nurses, etc. to integrate their care for each patient.

Providers may receive incentive payments to help with the cost of achieving meaningful use. For example, physicians can obtain up to $65,000 under Medicaid and up to $44,000 for Medicare to develop EHRs.[6]

The Centers for Medicare & Medicaid Services (CMS) is providing a considerable amount of technical assistance to providers in the form of dashboards,

nationwide webinars, and the formation of communities of practice, which are groups of medical professionals who share a concern about moving toward electronic records and want to improve their knowledge.

While carrots and sticks are being deployed, many challenges lie ahead. Many medical practices still hand patients a clipboard to fill in with pen and ink, most physicians are not yet using electronic drug prescriptions, and most hospitals do not use computer-assisted physician ordering of medications even though the technology is decades old and has been shown to avoid medical errors and save lives. Another challenge is to ensure interoperability across different e-health systems so that data can be exchanged within and across communities. Ensuring the security of patient information is also critical. Despite a good start, much more work needs to be done.

Initiative Two: Evaluate New Technology and Target to Patient Clinical Needs

Cost-effectiveness determinations should incorporate measures of success that include such traditional measures as risk-adjusted mortality, complications of surgery, and ambulatory-sensitive admissions to hospitals, but also factor in measures that may fall outside of the medical model, such as enhanced mobility and the ability to return to work or school, and the ability to work more productively. It is also important to build in ways to determine the subpopulations for whom a particular new technology would be very effective, and those for whom this technology would have a limited positive impact, or in some cases none at all. Payment systems need to take such information into account rather than making up-or-down decisions about technology approval that apply to all patients, regardless of whether clinical criteria indicate a need for this treatment.

Technology assessments must be updated every few years to accommodate new information about effective uses of products and procedures and changing costs over time. Technology appraisals should build in the need to improve adherence to clinical practice standards and reduce their variation. The findings of literature reviews should be supplemented by data on the real-life performance of interventions and be integrated into technology assessments to build clinical input into all phases of the analysis.

Initiative Three: Improve Care Management for People with Chronic Illnesses

Many care management strategies show great promise. Based on the author's research, new approaches to the management of chronic illnesses include:

- Patient registries for chronic diseases
- Patient reminder notices for appointments and preventive screening tests
- Regular and periodic diabetes screening for glucose, and measurement of lipids, blood pressure, and kidney function; and eye exams
- Intensive home environmental assessments and amelioration for patients with asthma

- Home visits after hospital discharge (e.g. by nurse practitioner) in situations such as prenatal and postpartum care for high-risk pregnancies
- Medication management to improve adherence
- Strong individualization of treatment plans customized to each patient
- Coordination of care across multiple providers, using team-based care
- Targeting these interventions to sicker patients who are likely to generate high costs in the future
- Intensive, multidisciplinary hospital pre-discharge planning and counseling, with continuous follow-up
- Telephonic interventions that are time-sensitive, frequent, and individually engage the patient regarding clinical metrics and subjective assessments of medical conditions over time
- Education and patient self-management
- Health information technology that is highly interactive with patients, facilitates contact with and among clinicians, and provides information and decision support to clinicians[7]

Initiative Four: Move Away From Open-Ended, Fee-for-Service System to Bundled Payments

Under the prevalent fee-for-service payment system in Medicare affecting three-fourths of enrollees, all providers are treated alike.[8] In this world where patients may see "any willing provider," the worst doctor gets paid the same as the best doctor, with few exceptions. No smart purchaser pays his best supplier of goods or services the same as his worst supplier. Nor would a smart purchaser keep doing business with suppliers that do a consistently poor job. This feature of Medicare has to change.

There is no reason to privatize Medicare in order to make this change. The current system is a bewildering maze of thousands of administered prices. The way providers make money in this system is to proliferate services, a temptation fostered by a malpractice system that encourages defensive medicine. Newly forming accountable care organizations (ACOs), organizations of health care providers that will be rewarded by Medicare and Medicaid for meeting targets related to improved health outcomes and reduced total health spending, will be experimenting with both new delivery models and new payment systems.

One such payment option is to make a bundled payment for an episode of care, such as a hospital admission and follow-up after hospital discharge. This would bundle hospital, physician, and other clinical services into a single rate. For example, the Geisenger Health System's Proven Care model offers a flat payment for surgery and all related care for 90 days after discharge. Geisenger experienced a 10-percent drop in readmissions in the first year of this program, shorter average lengths of stay, and reduced hospital charges.[9] A step further would be global payments. Under the most common form,

capitation payments, payers offer an all-inclusive payment per enrollee for a defined scope of services, regardless of how much care is actually provided. For example, Blue Cross Blue Shield of Massachusetts offers an alternative quality contract (AQF) that combines a health status-adjusted global payment with performance incentives for meeting quality and safety benchmarks.[10]

Starting in October 2012, Medicare will reward hospitals that provide high-quality care for their patients through the new Hospital Value-Based Purchasing Program. Hospitals across the country will be paid for inpatient acute care services based on the quality and not just the quantity of the services they provide. Changing how Medicare pays for hospital inpatient acute care services is expected to foster better quality of care for all hospital patients. In FY 2013, the Hospital Value-Based Purchasing Program will distribute an estimated $850 million to hospitals based on their overall performance on a set of quality measures that have been linked to improved clinical processes of care and patient satisfaction. This new program will be funded from monies that Medicare otherwise would have spent for unnecessary hospital stays, and the size of the fund will gradually increase over time, resulting in a shift from payments based on volume to payments based on performance.[11]

Initiative Five: Focusing on Community-Based Prevention

As noted in an Institute of Medicine report, "… the vast majority of health care spending, as much as 95 percent by some estimates, is directed toward medical care and biomedical research. However, there is strong evidence that behavior and environment are responsible for over 70 percent of avoidable mortality, and health care is just one of several determinants of health."[12]

We need to focus more resources on the factors that drive people into the physician's office, the emergency room, or the hospital in the first place. This includes such behavior and lifestyle factors as smoking, poor nutrition, and lack of exercise. Also important to public health are the safety of the home environment, the cleanliness of the air we breathe, and the safety of the food we eat.

The Affordable Care Act also creates a Prevention and Public Health Fund with $15 billion in funding. The challenge will be to target this funding to proven programs that can be brought to scale with the fund's seed capital. For example, the Diabetes Prevention Program, funded by the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC), studied the differences in outcomes among at-risk diabetes patients. Some received an aggressive lifestyle intervention, others received a drug used to treat diabetes, and a third group got a placebo. The aggressive lifestyle intervention in this study emphasizes improving dietary choices, increasing physical activity, improving coping skills, and providing group support to help participants lose 5–7 percent of their body weight and get at least 150 minutes

per week of moderate physical activity. These measures were shown to reduce the risk of developing Type 2 diabetes by 58 percent among people at high risk for the disease. The Indiana University School of Medicine administered a similar program in a group setting at the YMCA of Greater Indianapolis and saw similar results. Due to these successes, the CDC and YMCA began rolling out the program nationally in April 2010.[13]

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Notes

1. *Chronic Care: Making the Case for Ongoing Care*, Website of the Robert Wood Johnson Foundation, updated 2010. (http://www.rwjf.org/pr/product.jsp?id=56974)
2. Stephen Zuckerman, Aimee F. Williams, and Karen Stockley. "Trends in Medicaid Physician Fees, 2003–2008," *Health Affairs.* 28 April 2009. W510-W519.
3. National defense would account for just two percent of the growth, and programs for children, another 1.2 percent. Both of these last two tiny fractions, however, would be negative if the health care spending portion of the totals were removed. All other outlays would essentially be flat (a very small decline of $7 billion (-0.6 percent). Eugene Steuerle. "Presentation to Health Management Associates." May 13, 2011.
4. "Administration Implements New Health Reform Provision to Improve Care Quality, Lower Costs," posted on April 29, 2011, healthcare.gov. (http://www.healthcare.gov/news/factsheets/2011/04/valuebasedpurchasing04292011a.html)
5. HealthGrades, *HealthGrades 2011 Healthcare Consumerism and Hospital Quality in America Report,* 2011. (http://www.healthgrades.com/business/img/HealthcareConsumerism HospitalQualityReport2011.pdf)
6. "Medicare and Medicaid Programs; Electronic Health Record Incentive Program; Proposed Rule," Centers for Medicare and Medicaid Services, Federal Register, January 13, 2010. (http://edocket.access.gpo.gov/2010/E9-31217.htm)
7. Jack Meyer and Barbara Smith, "Chronic Disease Management: Evidence of Predictable Savings," Health Management Associates. November 2008.
8. Some 24.2 percent of Medicare enrollees are in a managed care plan. (http://www.mcareol.com/factshts/factnati.htm)
9. A.S. Casale et al. "ProvenCare': A Provider-Driven Pay-for-Performance Program for Acute Episodic Cardiac Surgical Care," *Annals of Surgery.* 246, no. 4 (2007): pp. 613–621.
10. Robert E. Mechanic and Stuart Altman, "Payment Reform Options: Episode Payment is a Good Place to Start," *Health Affairs.* 27 January 2009. W262-W270.
11. "Administration Implements Affordable Care Act Provision to Improve Care, Lower Costs," posted on April 29, 2011, U.S. Department of Health and Human Services. (http://www.hhs.gov/news/press/2011pres/04/20110429a.html)
12. Institute of Medicine. *The Future of the Public's Health in the 21st Century.* November 2002.
13. National Diabetes Prevention Program, Centers for Disease Control and Prevention. (http://www.cdc.gov/diabetes/projects/prevention_program.htm)